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MEDICARE+CHOICE

HCFA Actions Could Improve Plan Benefit and Appeal Information

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GAO/T-HEHS-99-108

Medicare+Choice: HCFA Actions Could Improve Plan Benefit and Appeal Information

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the quality of information that Medicare managed care organizations (MCO) distribute to beneficiaries and steps that the Health Care Financing Administration (HCFA) could take to ensure that this information is reliable, complete, and useful. HCFA's leadership in this area is important. The agency is responsible for approving all of the information that MCOs distribute and has the authority to set standards for that information. By successfully fulfilling this responsibility, HCFA can help make certain that MCOs provide the information that beneficiaries need to make informed health plan choices and understand their rights under Medicare managed care.

MCOs' Medicare plans differ from one another in the services they cover and the fees they charge.[1] At a minimum, plans must provide all Medicare-covered services, but many plans cover additional services, such as outpatient prescription drugs and routine physical examinations. Some plans charge a monthly premium (in addition to Medicare's part B premium), but others do not.[2] Although the Balanced Budget Act of 1997 (BBA) required HCFA to make available some basic comparative plan information, the membership literature that MCOs distribute remains the only source of detailed information that beneficiaries have about plans' fees and covered services. This information helps beneficiaries select a plan that fits their needs. Once they are enrolled, this information helps shape their understanding of their plan's obligations to its members. In addition, MCOs distribute other plan information that can affect the extent to which beneficiaries understand their rights, such as complaints about plan care. Consequently, it is vital that beneficiaries trust the plan information that they receive from MCOs and that HCFA ensures that their trust is not misplaced.

The importance of plan information will grow as the Medicare+Choice program, created by BBA, generates an expanded array of health plan alternatives to the traditional fee-for-service arrangement and attracts more and more beneficiaries to those options. In just the last 3 years, Medicare managed care enrollment has nearly doubled. Approximately 7 million of Medicare's 39 million beneficiaries (more than 17 percent) are

[1]A plan is a package of specific health benefits, fees, and terms of coverage. An MCO is an entity that offers one or more plans.

[2]Plans may charge other fees in addition to a monthly premium. However, plans cannot charge fees—in the form of monthly premiums, copayments, or other cost sharing—that are higher than what a beneficiary would likely pay under traditional Medicare.

currently enrolled in managed care plans. Informed choices will be particularly important as BBA phases out the opportunity for beneficiaries to disenroll from a plan on a monthly basis and moves toward the private sector practice of annual reconsideration of plan choice.

My comments today will focus on (1) the accuracy, completeness, and usefulness of the information Medicare MCOs distribute about their plans' benefit packages; (2) the extent to which MCOs inform beneficiaries of their plan appeal rights and the appeals process; and (3) HCFA's review, approval, and oversight of the plan information that MCOs distribute. My remarks are based on two recently released reports done for this Committee.[3]

In brief, we found problems with the benefit information distributed by all of the 16 MCOs we reviewed.[4] For example, although HCFA had reviewed and approved all of the information we examined, some MCOs misstated the coverage they were required by Medicare or their contracts to offer. One MCO advertised a substantially less generous prescription drug benefit than it had specified in its Medicare contract. In addition, some MCOs provided complete benefit information only after a beneficiary enrolled; others never provided full descriptions of benefits and restrictions. Finally, as we have reported previously, it is difficult to compare available options using literature provided to beneficiaries because MCOs use different formats and terminology to describe the benefit packages being offered. The variation in Medicare plan literature contrasts sharply with the uniformity of plan information distributed by MCOs that participate in the Federal Employees Health Benefits Program (FEHBP).[5] MCOs participating in FEHBP are required to provide prospective enrollees with a single, comprehensive, and comparable brochure to facilitate informed choice.

In our study of the appeals process, we found that when MCOs deny plan services or payment, they do not always inform beneficiaries of their appeal rights. Sometimes MCOs issue denial notices that do not contain all the information that HCFA requires. We also found that some MCOs delay issuing denial notices until the day before discontinuing services, such as

[3]Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999), and Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights (GAO/HEHS-99-68 Apr. 12, 1999).

[4]We examined the membership literature for 26 plans offered by 16 MCOs in four HCFA regions. We focused our review on three benefits: ambulance services, routine mammograms, and outpatient prescription drug benefits. A complete description of our scope and methodology is contained in GAO/HEHS-99-92.

[5]FEHBP is administered by the Office of Personnel Management (OPM).

skilled nursing care. This delay can increase a beneficiary's potential financial liability should the beneficiary appeal the plan's decision and lose.

Many of the information problems we identified regarding plan benefit packages and beneficiaries' appeal rights went uncorrected because of shortcomings in HCFA's review practices. In addition, HCFA has not exercised its authority to require MCOs to distribute plan information that is more complete, timely, and comparable. Agency officials recognize many of the shortcomings we identified and are beginning efforts to address them. However, we believe that the agency could do more. In our two accompanying reports, we recommend that HCFA undertake a variety of additional actions including (1) following the lead of FEHBP and requiring Medicare MCOs to distribute brochures that fully describe—using a prescribed format and terminology—plan benefits, fees, and coverage restrictions; and (2) setting standards for when MCOs distribute certain information and that the agency improve the consistency and thoroughness of its oversight practices. In commenting on our two reports, HCFA generally agreed with our recommendations.

Background

About two-thirds of all Medicare beneficiaries live in areas where they can choose among traditional fee-for-service and one or more managed care plans. Although approximately 82 percent of beneficiaries are in the fee-for-service program, the percentage of beneficiaries enrolled in managed care plans is growing. Over the last 3 years, Medicare managed care enrollment has nearly doubled to almost 7 million members, as of March 1999. Most Medicare managed care enrollees are members of plans that receive a fixed monthly fee for each beneficiary they enroll.

BBA Sought to Widen Health Plan Choices and Increase Availability of Comparable Information

In enacting BBA, the Congress sought to widen beneficiaries' health plan options. BBA permitted new types of organizations—such as provider-sponsored organizations and preferred provider organizations—to participate in Medicare. It also changed Medicare's payment formula to encourage the wider availability of health plans.

BBA also mandated that HCFA make available certain information to increase beneficiaries' awareness of their health plan options. The law directed HCFA to provide beneficiaries with general information about managed care plans through a variety of means, including a toll-free telephone number to answer general questions and an Internet site to

provide some basic comparative information about the various health care options available. HCFA is also required to mail basic comparative and other information to all beneficiaries. However, for detailed information about specific managed care plans, all of these resources direct beneficiaries to the MCOs that offer those plans—the only source for specific plan information.

HCFA Reviews Plan Benefit Information and Other Materials Distributed to Beneficiaries

To inform Medicare beneficiaries—both those interested in enrolling and those already enrolled—about plan-specific information, MCOs distribute membership literature—packets of information that describe plan benefits, fees, and coverage restrictions. Membership literature may be mailed to interested beneficiaries or distributed directly by sales agents who work for the MCO.

HCFA requires MCOs to include certain explanations in their member materials, such as provider restrictions; but otherwise, MCOs have wide latitude in what information is included and how it is presented. However, HCFA reviews all materials that MCOs distribute to beneficiaries. In addition to membership literature, HCFA reviews enrollment forms; administrative letters, such as those notifying beneficiaries of benefit changes; all advertising; and other informational materials. The review process is intended to help ensure that the information is correct and conforms to Medicare requirements. MCOs must submit these materials to HCFA, which has 45 days to conduct its review. If the agency does not disapprove of the materials within that period, the MCOs can distribute them.

MCOs Must Inform Beneficiaries of Their Appeal Rights

Medicare beneficiaries enrolled in a managed care plan have the right to appeal if their plan's MCO refuses to provide health services or pay for services already obtained. If an MCO denies a beneficiary's request for services—such as skilled nursing care or a referral to a specialist—it must issue a written notice that explains the reason for the denial and the beneficiary's appeal rights. Such notices must also tell beneficiaries where and when the appeal must be filed and that they can submit written information to support the appeal.

A beneficiary first appeals to his or her health plan's MCO by asking it to reconsider its initial decision. If the MCO's reconsidered decision is not fully favorable to the beneficiary, the case is automatically turned over to the Center for Health Dispute Resolution (CHDR)—a HCFA contractor that reviews the decision and may overturn or uphold it. Beneficiaries who are

dissatisfied with CHDR's decision have additional appeal options, provided certain requirements are met. A member who loses an appeal is responsible for the cost of any disputed health care services that were obtained. HCFA reviews each MCO's plan appeals process as part of its biennial evaluation of each organization's compliance with HCFA regulations.

Plan Benefit Information Is Not Always Correct, Current, or Complete and Is Not Readily Comparable

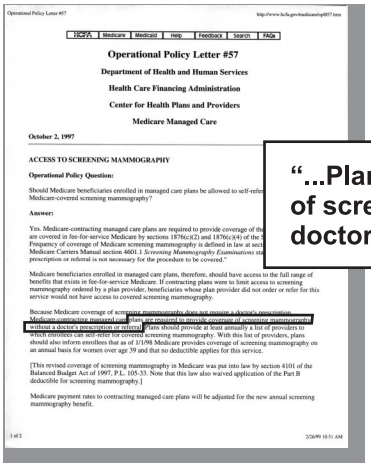
Our review of 16 Medicare MCOs found various types of flaws in the membership literature they distributed. The documents we examined were used by MCOs to inform prospective enrollees and members about covered services, fees, and restrictions. Although HCFA had reviewed and approved the documents, some incorrectly described plan benefit packages. In several instances, the information was outdated or incomplete. Some MCOs provided beneficiaries with detailed benefit information only after they had enrolled in a plan. We also found it difficult to compare benefit packages because MCOs are not required to follow common formats or use standard terms when describing their benefits. In contrast, each MCO that participates in FEHBP is required to distribute a single, comprehensive booklet that describes its benefit package using a standard format and standard terminology.

Plan Benefit Information Is Not Always Correct

Most MCOs' plan documents contained errors or omitted information about the three benefits we reviewed—prescription drugs, mammography, and ambulance services. Problems ranged from minor inaccuracies to major errors. For example, documents from five MCOs we reviewed erroneously stated that beneficiaries needed a referral to obtain a routine annual mammogram—a Medicare-covered service. HCFA policy clearly states that plans cannot require a referral for annual mammograms and must inform beneficiaries of this policy. (See fig. 1 for HCFA policy and excerpts from Medicare plan materials.)

Figure 1: Examples of Plan Referral Requirements for Screening Mammogram Contradicting Medicare Coverage

HCFA Operational Policy Letter #57



Operational Policy Letter #57

Department of Health and Human Services

Health Care Financing Administration

Center for Health Plans and Providers

Medicare Managed Care

October 2, 1997

ACCESS TO SCREENING MAMMOGRAPHY

Operational Policy Question:

Should Medicare beneficiaries enrolled in managed care plans be allowed to self-refer for Medicare-covered screening mammography?

Answer:

Yes. Medicare-contracting managed care plans are required to provide coverage of the ... are covered in fee-for-service Medicare by sections 1876(c)(2) and 1876(c)(4) of the ... Frequency of coverage of Medicare screening mammography is defined in law at sect... Medicare Carriers Manual section 4601.1 *Screening Mammography Examinations* sta... prescription or referral is not necessary for the procedure to be covered."

Medicare beneficiaries enrolled in managed care plans, therefore, should have access to the full range of benefits that exists in fee-for-service Medicare. If contracting plans were to limit access to screening mammography ordered by a plan provider, beneficiaries whose plan provider did not order or refer for this service would not have access to covered screening mammography.

Because Medicare coverage of screening mammography does not require a doctor's prescription, Medicare-contracting managed care plans are required to provide coverage of screening mammography without a doctor's prescription or referral. Plans should provide at least annually a list of providers to which enrollees can self-refer for covered screening mammography. With this list of providers, plans should also inform enrollees that as of 1/1/98 Medicare provides coverage of screening mammography on an annual basis for women over age 39 and that no deductible applies for this service.

[This revised coverage of screening mammography in Medicare was put into law by section 4101 of the Balanced Budget Act of 1997, P.L. 105-33. Note that this law also waived application of the Part B deductible for screening mammography.]

Medicare payment rates to contracting managed care plans will be adjusted for the new annual screening mammography benefit.

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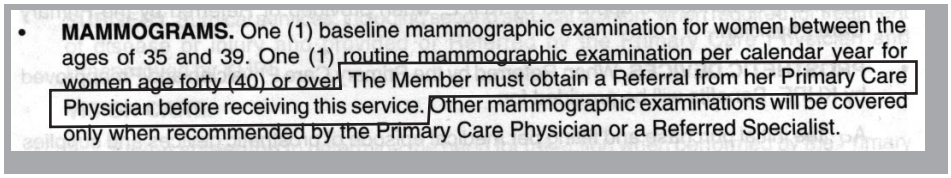
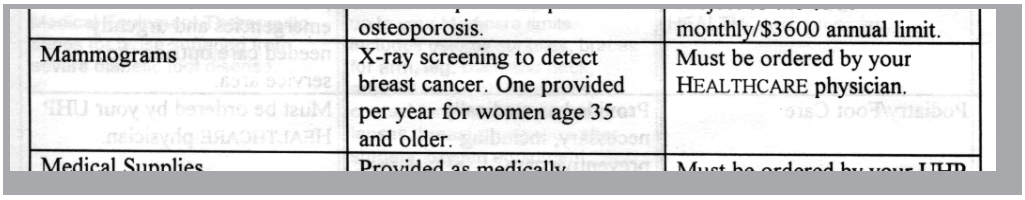
"...Plans are required to provide coverage of screening mammography without a doctor's prescription or referral..."

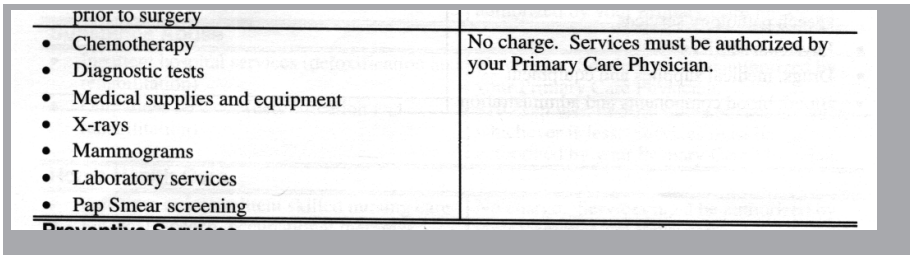
Excerpts From Medicare 1998 Plan Materials



- **MAMMOGRAMS.** One (1) baseline mammographic examination for women between the ages of 35 and 39. One (1) routine mammographic examination per calendar year for women age forty (40) or over. The Member must obtain a Referral from her Primary Care Physician before receiving this service. Other mammographic examinations will be covered only when recommended by the Primary Care Physician or a Referred Specialist.



	osteoporosis.	monthly/$3600 annual limit.
Mammograms	X-ray screening to detect breast cancer. One provided per year for women age 35 and older.	Must be ordered by your HEALTHCARE physician.
Medical Supplies	Provided as medically	Must be ordered by your UHP



prior to surgery	
• Chemotherapy • Diagnostic tests • Medical supplies and equipment • X-rays • Mammograms • Laboratory services • Pap Smear screening	No charge. Services must be authorized by your Primary Care Physician.
Preventive Services	

Note: Sources as indicated in figure. Emphasis added.

We also found serious problems with plan information regarding coverage for outpatient prescription drugs—a benefit that attracts many beneficiaries to Medicare managed care plans. For example, a large, experienced MCO specified in its Medicare contract that its plan would provide brand name drug coverage of at least $1,200 per year. However, the plan's membership literature indicated lower coverage limits—in some areas as low as $600 per year. Based on 1998 enrollment data, we estimate that over 130,000 plan members may have been denied part of the benefit to which they were entitled and for which Medicare paid. Another MCO, which used the same documents to promote its four plans, stated in its handbook that all plan members were entitled to prescription drug coverage. However, only two of the MCO's four plans provided such coverage. A third MCO provided conflicting information about its drug coverage. Some documents stated that the plan would pay for nonformulary drugs,[6] while other documents said it would not.

Some Plan Benefit Information Is Outdated

Some MCOs distributed outdated information, which could be misleading. HCFA allows this practice if MCOs attach an addendum updating the information. HCFA officials believe this policy is reasonable because beneficiaries can figure out a plan's coverage by comparing the changes cited in the addendum with the outdated literature. However, we found that some MCOs distributed outdated literature without the required addendum and that when MCOs included the addendum, it often did not clearly indicate that the addendum superseded the information contained in other documents. In addition, some MCOs did not put dates on the literature they distributed, which obscured the fact that the literature was no longer current.

Some MCOs Did Not Provide Complete Benefit Information

Some MCOs did not disclose important plan information, including information about Medicare required benefits, in documents designed to provide detailed plan information. For example, most MCOs we reviewed did not provide detailed information about ambulance services—a Medicare-required benefit. One MCO did not mention ambulance service coverage at all in any of the documents we reviewed. Three MCOs stated that ambulance services were covered "per Medicare regulations" but did not explain Medicare's coverage. Most of the other MCOs' documents

[6]A drug formulary is, in general, a list of drugs that MCOs prefer their physicians to use in prescribing drugs for enrollees. The formulary includes drugs that MCOs have determined to be effective and that suppliers may have favorably priced to the MCO. Any drug not included on a formulary is considered a nonformulary drug.

provided general descriptions of their plans' ambulance coverage but did not explain the extent of the coverage.

HCFA's instructions regarding benefit disclosure are vague, only advising MCOs to provide information sufficient for beneficiaries to make informed enrollment decisions. Moreover, MCOs that adopted HCFA's suggested disclosure language may send beneficiaries to an information dead end. In the guidelines it provides to MCOs, HCFA suggests that a plan's member policy booklet (or other document used to describe a plan's benefit package) direct beneficiaries to the MCO's Medicare contract for full details of the plan. According to HCFA, a member policy booklet should state that the document

> constitutes only a summary of the [plan]. . . . The contract between HCFA and the [MCO] must be consulted to determine the exact terms and conditions of coverage.

HCFA officials responsible for Medicare contracts, however, said that if a beneficiary were to request a copy of the contract, the agency would not provide it due to the proprietary information included in an MCO's contract proposal. Furthermore, an MCO is not required to provide beneficiaries with copies of its Medicare contract. MCO officials with whom we spoke differed in their responses about whether their organizations would provide beneficiaries with copies of their Medicare contracts.

Some MCOs we reviewed provided detailed benefit information only after beneficiaries had enrolled. The information packages distributed by several MCOs we reviewed stated that beneficiaries would receive additional, detailed descriptions of plan benefits, costs, and restrictions following enrollment. In addition, four MCOs did not provide 1998 benefit details until several months after the new benefits took effect.[7] In fact, one MCO did not distribute its detailed benefit information until August—8 months after the benefit changes had taken effect.

[7]Plan contracts, which define plans' benefit packages, generally take effect January 1 of each year and run for 1 calendar year.

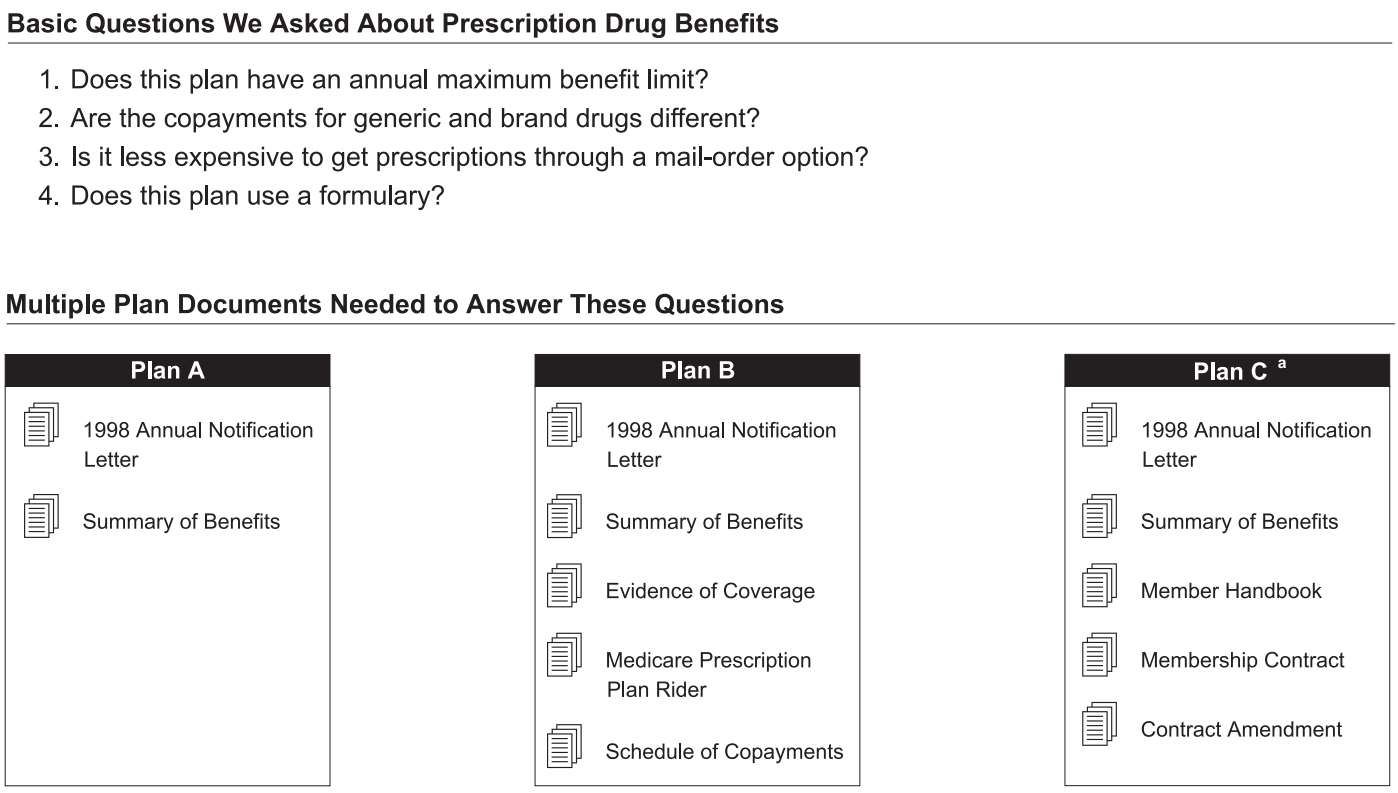
Plan Benefit Information Was Not Readily Comparable

The membership literature we reviewed varied considerably in terminology, depth of detail, and format. These variations are similar to those that we encountered in previous reviews undertaken for this Committee and greatly complicated benefit package comparisons.[8] The lack of clear and uniform benefit information likely impedes informed decisionmaking. HCFA officials in almost every region noted that a standard format for key membership literature, along with clear and standard terminology, would help beneficiaries compare their health plan options.

To illustrate this problem, we identified the location in each MCO's plan literature where enrollees would find answers to basic questions regarding coverage of the three benefits we studied. This information was often difficult to find; enrollees would have to read multiple documents to answer the basic coverage questions. For example, to understand the three plans' prescription drug benefits, we had to review 12 different documents: 2 from Plan A, 5 from Plan B, and 5 from Plan C. (See fig. 2.)

[8]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 23, 1996); Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices (GAO/T-HEHS-98-162, May 6, 1998); and GAO/HEHS-99-92, Apr. 12, 1999.

Figure 2: Multiple Plan Documents Needed to Answer Basic Drug Benefit Questions



[a]Plan documents contradict one another as to whether the plan will cover a nonformulary drug.

Source: GAO analysis of MCO plan membership literature.

It was also not easy to know where to look for the information. For example, the answer to our question about whether a plan used a drug formulary was found in Plan A's summary of benefits, in Plan B's Medicare prescription drug rider, and in Plan C's contract amendment. Plan C's materials required more careful review to answer the question because the membership contract indicated the plan did not provide drug coverage. However, an amendment—included in the member contract as a loose insert—listed coverage for prescription drugs and the use of a formulary.

Each FEHBP Plan Distributes a Single, Standard, Comprehensive Benefit Booklet

To avoid the types of problems found in Medicare MCOs' membership literature, OPM requires each participating health plan to describe, in a single document, its benefit package—that is, covered benefits, limitations, and exclusions—and to include a benefit summary in a standardized language and in OPM's prescribed format. OPM officials update the mandatory language each year to reflect changes in the FEHBP requirements and to respond to organizations' requests for improvements. Finally, OPM requires health plans to distribute plan brochures prior to the FEHBP annual open enrollment period so that prospective enrollees have complete information on which to base their decisions. OPM officials told us that all participating plans publish brochures that adhere to these standards.

Adequate Information About Appeals Process and Beneficiary Rights Is Often Not Provided

Plan membership literature is required to contain information on beneficiaries' appeal rights. In addition, beneficiaries are supposed to be informed of their appeal rights when they receive a plan's written notice denying a service or payment. HCFA requires denial notices to contain information telling beneficiaries where and how to file an appeal. Furthermore, denial notices are required to state the specific reason for the denial because vaguely worded notices may hinder beneficiary efforts to construct compelling counterarguments. Vague notices may also leave beneficiaries wondering whether they are entitled to the requested services and should appeal. Finally, HCFA regulations state that whenever MCOs discontinue plan services, such as skilled nursing care, they must issue timely denial notices to beneficiaries.

Substantial evidence indicates, however, that many beneficiaries did not receive the required information when their MCOs denied services or payment for services. Denial notices were frequently incomplete or never issued, and many notices did not indicate the specific basis for the denial. Furthermore, beneficiaries often received little advance notice when their MCO discontinued plan services.

Denial Notices Are Sometimes Incomplete, Never Issued, or Do Not Indicate Specific Reasons for the Denial

Reviews by HCFA, studies by the Department of Health and Human Services' Office of Inspector General (OIG), as well as studies we conducted found numerous instances of incomplete or missing denial notices. In 1997, HCFA performed monitoring visits to 90 MCOs; about 13 percent of these MCOs were cited for failing to issue denial notices. In addition, nearly one-quarter of the 90 MCOs were cited for issuing denial notices that did not adequately explain beneficiaries' appeal rights. Two

studies by the OIG, using different methodologies, provide additional evidence that beneficiaries are not always informed of their appeal rights.[9] In one study, the OIG surveyed beneficiaries who were enrolled or had recently disenrolled from a managed care plan. According to the survey results, 41 respondents (about 10 percent) said that their health plans had denied requested services. Of these, 34 (83 percent) of the respondents said that they had not received the required notice explaining the denial and their appeal rights.

Most notices that we reviewed contained general, rather than specific, reasons for the denial. In 53 of the 74 CHDR cases that contained the required denial notices (notices were missing in 32 other cases), the notices simply said that the beneficiary did not meet the coverage requirements or contained some other vague reason for the denial. Likewise, representatives from several advocacy groups told us that in cases brought to their attention, the denial notices were often general and did not clearly explain why the beneficiary would not receive, or continue to receive, a specific service.

Notices of Discontinued Coverage Are Often Issued the Day Before Services Are Stopped

HCFA regulations state that whenever MCOs discontinue plan services, they must issue timely denial notices to beneficiaries. The regulations, however, do not specify how much advance notice is required before coverage is discontinued. Beneficiaries who receive little advance notice may not be able to continue to receive services because of their potential financial liability. If the beneficiary appeals and loses, he or she is responsible for the cost associated with the services received after the date specified in the denial notice.

In three of the MCOs we visited, the general practice was to issue the denial notices the day before the services were discontinued. We found that many skilled nursing facility (SNF) discharge notices were mailed to the beneficiary's home instead of being delivered to the facility. In other cases, it appeared that the beneficiary or his or her representative received the notice a few days after the beneficiary had been discharged from the SNF or the SNF coverage had ended. Ten of the 25 SNF discharge cases we reviewed at CHDR also involved the receipt of a notice after the patient had been discharged.

[9]Department of Health and Human Services, OIG, Medicare HMO Appeal and Grievance Processes, Review of Cases (OEI-07-94-00283, Dec. 1996), and Medicare HMO and Grievance Processes, Beneficiaries' Understanding (OEI-07-96-00281, Dec. 1996).

The fourth MCO we visited issued SNF discharge notices 3 days prior to the discharge date. This lead time helped ensure that a beneficiary received the notice before the discharge date. It also allowed more time for the beneficiary to file an expedited appeal and receive a decision from the plan. Consequently, beneficiaries in this MCO's plan who appeal and lose are less exposed to the SNF costs incurred during the appeals process. Officials from all the MCOs we visited said that, in almost every instance, the decision to discharge a beneficiary from a SNF is made days in advance and that discharge notices could be issued several days prior to discharge.

Weaknesses in HCFA's Review Processes and Requirements Allowed Problems in Plan Materials to Go Uncorrected

Although HCFA reviews and approves all materials that MCOs distribute to beneficiaries, weaknesses in the agency's review practices and information standards allowed the plan information problems we observed to go uncorrected. One weakness is that HCFA reviewers must rely on a faulty document to determine whether plan member materials are correct. In addition, HCFA review practices are sometimes inadequate to detect or correct the problems we found. Finally, HCFA has not used its authority to require that MCOs use a common format and terminology to describe their plans' benefit packages.

HCFA's Standard for Gauging Accuracy in Plan Materials Is Faulty

To ensure the accuracy of membership literature, HCFA reviewers are instructed to compare each MCO's membership literature to its Medicare contract. Specifically, HCFA reviewers are expected to rely on one particular contract document—the Benefit Information Form—which summarizes plan benefits and member fees. Reviewers told us, however, that this contract document often does not provide the detail they need. Consequently, they sometimes rely on benefit summaries provided by the MCOs to verify the accuracy of plan information. This practice is contrary to HCFA policy, which requires an independent review of MCOs' plan literature. The reviewer who approved the plan literature advertising a $600 annual drug benefit, instead of the contracted $1,200 annual limit, said that the mistake was caused by her reliance on a benefit summary provided by the MCO.

HCFA's Monitoring Practices Allowed Problems to Go Uncorrected

Inadequate monitoring of MCOs' communications with beneficiaries—both about plan benefit packages and appeal rights—allowed the problems we observed to go uncorrected. For example, we found instances where MCOs agreed to make HCFA required changes, but the final printed documents did not incorporate the changes. Because HCFA staff generally do not receive

copies of the printed documents, they are often unaware as to whether MCOs have made the required corrections.

Shortcomings in HCFA's monitoring procedures also limit the agency's ability to ensure that beneficiaries know that plans' service and payment decisions can be appealed. For example, to determine whether MCOs informed beneficiaries of their appeal rights, HCFA's monitoring protocol requires agency staff to review a sample of appeal case files. HCFA staff check these files to determine whether each contains a copy of the required denial notice. However, it seems reasonable to assume that beneficiaries who appeal are more likely to have been informed of their rights than those who do not appeal. Yet, HCFA does not generally check cases where services or payment for services were denied but not appealed. Furthermore, when MCOs contract with provider groups to perform certain administrative functions, such as issuing denial notices, HCFA staff generally do not check to see that the delegated duties were carried out in accordance with Medicare requirements.

Inadequate Instructions to MCOs Hamper HCFA's Review Process

HCFA has the authority to set standards for the format, content, and timing of the plan information that MCOs distribute to beneficiaries. Unlike OPM, however, HCFA has made little use of its authority. Instead, each MCO decides on the format—and to large extent, content and timing—of the plan information it distributes.

In addition to making plan comparisons more difficult, the lack of common information standards has adversely affected HCFA's review process. First, the lack of standards has resulted in inconsistent review practices and misleading comparisons. For example, one MCO representative told us that several MCOs' plans in its market area required a copayment for ambulance services if a beneficiary was not admitted to a hospital, but not every MCO was required to disclose that fact. Consequently, although the plans had similar benefit restrictions, the MCOs that were required to disclose the plan restrictions appeared to offer less generous benefits than the other MCOs' plans.

The lack of information standards also increased the amount of time needed to review and approve plan documents and increased the likelihood of undetected errors. Agency staff said that they could do a better job checking plan membership literature for accuracy and completeness if every MCO presented its plan information in a common format and used standard terminology. Staff also said they spend a

considerable amount of time reviewing plan documents that could be standard administrative forms—such as member enrollment applications—and thus had less time to spend reviewing important documents describing plan benefits.

HCFA Has Begun Efforts to Correct Problems and Shortcomings in Plan Information

HCFA is moving to address some of the problems and systemwide shortcomings we identified during our recent reviews. For example, HCFA is working to revise the contract document that agency reviewers use to verify the accuracy of plan information. The proposed new contract document will help ensure that HCFA collects the same information from each plan and presents the information in a consistent format and in greater detail than the current document. The agency expects to test this new document later this year and fully implement it in 2000. HCFA officials believe that the Office of Management and Budget's clearance process for the proposed new contract document must begin no later that August 1999 to meet this timetable. Otherwise, full implementation could be delayed.

Agency officials recognize the importance of more uniform membership literature and have articulated their intent to standardize key documents in future years. As a first step, the agency established a work group—consisting of representatives from HCFA, MCOs, senior citizen advocacy groups, and other relevant entities—to develop a standard format and common language for MCOs' plan benefit summaries. HCFA hopes to establish these new standards by next month so MCOs' fall 1999 benefit summary brochures can follow the new standards. HCFA's long-term goals involve the establishment of standards for other key documents. However, the agency has not yet developed a strategy for its long-term efforts or decided whether the information standards it sets will be voluntary or mandatory.

HCFA officials said they have also undertaken several initiatives to help ensure that beneficiaries are informed of their appeal rights and the steps necessary to file an appeal. Sometime this year, HCFA intends to publish additional instructions regarding the content of denial notices. The agency will also revise its monitoring protocol to better ensure that MCOs issue the required denial notices. Finally, HCFA is working to develop timeliness requirements for the issuance of notices when MCOs reduce or discontinue services, such as skilled nursing care, home health care, or physical therapy.

Conclusions

As the Medicare+Choice program grows and more health plan options become available, the need for reliable, complete, and useful information will increase. In our recent reviews, however, we found major problems in the plan information that some MCOs provided to beneficiaries. In several instances the information was incorrect or incomplete; in other cases, the problem was poor timing—important information was distributed long after the benefit package had changed or only after beneficiaries had enrolled in a plan. None of the information was provided in a format that facilitated comparisons among plans. We also found that some MCOs did a poor job informing beneficiaries about their appeal rights and the appeals process.

HCFA has both the authority and the responsibility to ensure that Medicare MCOs distribute information that helps beneficiaries make informed decisions. To date, however, its policies and practices have fallen short of that mark. HCFA's review of plan information has been inadequate and has not prevented plans from distributing incorrect and incomplete information. Furthermore, unlike OPM, HCFA has not set standards for plan information that could facilitate informed decisions. The agency is taking some steps to address the problems we identified. We believe, however, that these problems will not be fully addressed until HCFA implements our past and current recommendations by setting information standards for MCOs and requiring them to adhere to those standards.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee might have.

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